ASSISTED LIVING FACILITY (ALF) COST REPORT

1. Cost Report Period

(Start date) _____   **(Ending date)**   _____

2. Facility Information

Name of ALF Facility _____

Address of Facility   _____

(City)   _____, **(State)**_____(**Zip**)_____

Mailing Address (if different) _____

(City)   _____, **(State)**_____(**Zip**)_____

3. Net Operating Revenue

	Sources	Revenue Amount $
A	Revenue from Private Pay Residents	
B	Total Revenue from Auxiliary Grant Recipients	
C	Assisted and Intensive Living (DMAS) Revenue	
D	All Other Net Operating Revenue	
E	Total Net Operating Revenue	

4. Certification

I certify that the information submitted with this cost report is true and complete and that the services provided were in accordance with licensing provisions and without regard to race, color, national origin, sex, age, political affiliation, religion, or handicapping condition. I futher certify that the actual cost data submitted is accurate to the best of my knowledge and the expenditures were reasonable, necessary and appropriate for the services provided.

_____   _____   _____
  Signature of Owner or Administrator   **Title**   **Date**

_____   _____   _____
Print Name of Owner or Administrator   **Area Code**   **Phone Number**

5. Net Operating Expenses

	Categories	Expenses $
A	Salaries, Wages and Benefits	
B	Food Supplies	
C	Utilities/Fuel	
D	Facility: Rent/Lease/Interest/Depreciation	
E	Facility: Maintenance and Repair expenses	
F	All Other Net Operating Expenses	
G	Total Net Operating Expenses	

6. Patient/Bed Days

	Categories	Bed Days
A	Total Capacity (total average licensed beds multiplied by days in reporting period)	
B	Total Days from Line A Above Multiplied by 85% (.85) Enter Result Total	x .85 =
C	Actual (or actual average) Patient/Bed Days Filled During Reporting Period	
D	Enter the Greater Number from Either Line B or Line C	

7. Rate Calculation

	Categories	Results
A	Enter the Total Net Operating Expenses (from table 5G)	
B	10% Operations Growth (**for-profit ALF's only**) Added: Total Operating Expenses from Line A Above Multiplied by 110% (1.10) Enter Result Total	x 1.10 =
C	Inflation Adjustment of 3.0% Added: Total Operating Expenses from Line A or Line B Above Multiplied by 103.0% (1.030) Enter Result Total	x 1.030 =
D	Enter the Number from Patient/Bed Days Table 6, Line D	
E	Enter the Daily Cost of Service (line C total divided by line D above)	
F	Monthly Cost (Rate) of Service (line E multiplied by average days in a month, 30.417) Enter Result Total	x 30.417 =